DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		NSTRUCTION 00	(X3) DATE COMPL	ETED
		15G116	B. WIN	G		05/16/	2013
	PROVIDER OR SUPPLIER			1734 JE	.ddress, city, state, zip code :FFREY DR L, IN 46356		
ARC OF	NORTHWEST IND			LOWEL	L, IN 40350		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000000							
	This visit was fo	un a fundamental	11/0	00000			
			WU	00000			
	recertification ai	nd state licensure survey.					
	Dates of Survey	: 5/1, 5/2, 5/3, 5/9, 5/10					
	and 5/16/13.						
	Facility Number	:: 00653					
	Provider Numbe	er: 15G116					
	AIMS Number:	100234070					
	THIND INMINOCI.	10025 1070					
	Surveyors:						
	Paula Chika, QI	DP TC					
	, ,						
	Christine Colon,	, QIDP					
	There defects	in also well activities					
		ies also reflect state					
	findings in accor	rdance with 460 IAC 9.					
	Quality review of	completed May 24, 2013					
	by Dotty Waltor	ı, QIDP.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLET		
		15G116	B. WIN			05/16/	2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR			
ARC OF	NORTHWEST INDI	ANA INC. THE			L, IN 46356			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCE		DATE	
W000140	483.420(b)(1)(i) CLIENT FINANCI	F8						
		establish and maintain a						
		res a full and complete						
		ents' personal funds						
		acility on behalf of clients.						
		review and interview, the	W0	00140	Client #3 was in possession of	:	06/15/2013	
		maintain an accurate			the \$12.95; however, staff did	not		
		m for 1 of 3 sampled			accurately document this on the			
), for whom the facility			budget sheet. Budget sheet w			
		ersonal funds' accounts.			reconciled to reflect the correct documentation. The Service	ι		
	managed then pe	cromar rands accounts.			Coordinator will re-audit all clie	ent		
	Eindings in aluda				budget sheet and funds at the			
	Findings include				home to ensure no further erro	ors		
					were made by 6/15/13. The			
		facility's records was			process for safely maintaining			
	conducted at the	group home on $5/1/13$ at			client funds is being revised.	c		
	6:45 P.M. A rev	riew of clients #3's			Once this is completed all staf will be retrained on the proces			
	personal petty ca	sh financial record			including modeling and return	3		
	indicated the foll	lowing:			demonstrations of the needed			
					skills. Service Coordinators w	ill		
	Client #3's perso	nal financial accounting			ensure the financials are			
	-	5/13 indicated he should			completed biweekly and the			
	_	f \$12.95. Direct Support			Behavioral Health Director will			
		• •			ensure that a random audit of client financials is completed			
	`	(DSP) reviewed the			each month, and then will fade	e to		
	=	t #3's petty cash pouch.			quarterly audits once proficien			
		oney in client #3's			in the new system is established			
		sh funds pouch to						
	review.							
	An interview wit	th DSP #1 was conducted						
	on 5/2/13 at 10:3	30 A.M. DSP #1						
	indicated each cl	ient's ledger entry						
		currency amount should						
		OSP #1 further indicated						
	there was no mor							
	uicie was no mo	ncy to count.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 2 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G116			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/16/2013
	PROVIDER OR SUPPLIE		STREET 1734 J	ADDRESS, CITY, STATE, ZIP CODE EFFREY DR LL, IN 46356	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	9-3-2(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 3 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING			ETED
		15G116	B. WIN			05/16/	2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		LOWELL, IN 46356			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
W000149	483.420(d)(1) STAFF TREATMI The facility must of written policies are mistreatment, neg Based on observer record review for (#2) and for 2 and #5), the facility of policy and proces of clients in regard aggression where of 5 incidents regarded to implement procedures to convestigations in client abuse/aggrunknown sources an allegation of procedure and procedure an	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. ation, interview and r 1 of 3 sampled clients ditional clients (#4 and failed to implement its dures to prevent neglect rd to client to client the there was a pattern of 5 wiewed. The facility tent its written policy and induct thorough regard to the client to ression, injuries of the elopement/neglect and the possible client to client the facility also failed to licy and procedures to the of possible sexual the tent of the clients.	WO	00149	An IDT meeting was held to investigate the incidents regarding clients #2 and #4 on 5/13/13. No abuse, neglect or exploitation was suspected du these incidents. Client # 5 will have an IDT by 6/10/13 to rule abuse, neglect or exploitation modifications to his plan and recommendations will follow the Behavior Plans for clients and #4 have been revised to indicate that both clients are to monitored for the remainder of the day following any aggressi An IDT meeting will occur with 24 hours of any episode of client aggression to determ if abuse, neglect, or exploitation occurred. Protective measure will be put into place to ensure safety of all clients following aggression. To ensure future compliance, posters explaining client rights and reporting requirements were distributed all group homes and the day program so that staff and client become more aware of the requirements on an ongoing basis. Additionally, all staff will trained on reporting and investigation requirements for Abuse, Neglect, and Exploitatiat least annually unless chang occur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need requires this to be and the staff and client at least annually unless changoccur or need re	ring ring e out is f #2 be f on. ent ine on s the to to	06/10/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 4 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G116	B. WIN			05/16/2013	
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			EFFREY DR		
ARC OF	NORTHWEST IND	DIANA INC, THE			L, IN 46356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	DROUIDEDIG DE AN OF CORRECTION	(X	5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLI	ETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DAT	Έ
	[client #2] savii	ng that [client #2] could			done more frequently. To ensu	ıre	
		at to do. [Client #2] then			that Service Coordinators are		
					trained on reporting and		
	^ -	#4] which made [client #4]			investigation requirements for		
		onto his buttocks." The			abuse, neglect (including the		
		ient #4 was not injured.			neglect of medical care),		
		ed "Bx (behavior) Plan			exploitation and injuries of unknown origin, the Behaviora	,	
	in place to addr	ess aggression. Plan			Health Director will review the		
	appears to over	all be effective incidents			training records at least annua		
	within normal r	range (sic)"			and document review of findin	gs.	
					Area Managers will review DS		
	-10/21/12 "[Cli	ent #2] was talking with			training records to ensure they		
	-	#4] said 'shut up' to [client			have been training at least	of .	
	-	then hit him (client #4)			annually and document review findings. All new Service	OI	
		• , ,			Coordinators and DSPs will be		
	_	ing. Staff separated,			trained on reporting and		
		old him that is not			investigation requirements for		
	* * *	he 10/12/12 I/A indicated			abuse, neglect (including the		
	client #4 was no	ot injured. The I/A report			neglect of medical care),		
	indicated the cl	ients were separated and			exploitation and injuries of		
	"monitored fo	or further aggression.			unknown origin prior to workin home or with a client. In addit		
	None occurred.	Behavior plans			the Service Coordinators will be		
	followed"	1			present in their homes at least		
					two times per month to ensure		
	_10/20/12 "[Cli	ent #2] was singing			protection of clients, address		
	-	, ,			concerns, monitor activities, e		
		s. [Client #4] got irritated			Documentation of visits will be		
	_	#2] to shut up while using			completed and will include specifics to the client as well a	c	
	1 1	macked [client #2] on his			the visit. The Behavioral Heal		
		report indicated client #2			Director will review progress		
	was not injured	. The 10/20/12 I/A			notes regularly. To ensure futu	ıre	
	indicated the cl	ients were separated and			compliance, The Service		
	monitored for f	urther aggression. The I/A			Coordinator will visit the client		
	report indicated	l "Behavior Plans			once a week at home and onc		
	followed."				week at the day services prog for two months to ensure	am	
					behavior plans are followed ar	_{ld}	
	10/12/12 "Dad	a aliants (aliants #2 and			recommendations put in place		
	-10/12/12 BOU	n clients (clients #2 and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 5 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDDIG	00	COMPL	ETED
		15G116		LDING		05/16/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANIA INIO TUE			EFFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		LOWEL	L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#4) were agitate	d on arrival (to work) &			are carried out. 6/14/13In addi		
	(and) staff direct	ted them to stay separate			to the submitted plan, a syster		
	` /	• •			for identifying and determining		
	& calm down. [Client #4] walked over into the area & [client #2] approached				cause/effect and preventative		
	_				approaches to incidents of	ha	
		you have to be like that &			client-to-client aggression will developed by 6/15/13. Client		
	-	after him (client #2) and			client aggression will be report		
	fight insued (sic). No punching more arm			to the administrator and BDDS		
	slapping." The	I/A indicated clients #2			applicable. If needed, an IDT		
	and #4 were not	injured. The I/S report			meeting will be held to discuss	6	
		#2 and #4's behavior			modifications to the milieu,		
	plans addressed				behavior plans, staff		
	pians addressed	aggression.			assignments, additional training		
					or disciplinary measures, or ot		
	_	: #4] hit [client #2] on his			issues specifically relevant to t		
	(R) (right) shoul	der." The I/A report			client/s. Once developed, staf will be trained on this system.	Ī	
	indicated client	#4 was redirected. The			The system will be monitored	hv	
	I/A report indica	ated client #2 was not			the Behavioral Health Director	-	
	injured.				designee who will review incid		
	l injuit va.				reports involving client to clien		
	The charge ment	ionad I/A rements of alient			aggression to ensure system		
		ioned I/A reports of client			compliance. Changes will be		
		ion/abuse indicated the			made if necessary to the syste	em	
	facility did not c	onduct an investigation in			as needed to assure the		
	regard to the inc	idents of			effectiveness of the methodolo	ogy.	
	aggression/abuse	e. The above mentioned			6/21/13 While present. Service		
	incidents of clien				Coordinators and Managers w	rill	
		e also indicated the			also monitor for client-to-client		
		put corrective measures			aggression, implementation of		
	_	-			proactive and reactive measur		
	_	ddressed the targeted			of the behavior plan, providing		
		ression between the			active treatment, goal training,		
	clients.				community outings, and		
					appropriate disposable of shar	ps.	
	Client #2's recor	d was reviewed on 5/2/13					
		ent #2's 3/13 Behavior					
		lient #2 demonstrated					
	verbai aggressio	n which was defined as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 6 of 47

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G116	(X2) MU A. BUILI B. WING	DING	00	(X3) DATE COMPI 05/16 .	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE FFREY DR L, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	The 3/13 plan aldemonstrated physics when any hitting others, or open or closed his behavior plan induction be separated from aggressive. The staff was to tell diare inappropriate much more effect her (sic) problem indicated facility the client to part relaxation exercification interviolent in the client did recontinued aggression behavioral intervible used. Client #2's 3/11/Plan (ISP) and/orindicated the client did not mediated the client did not mediated the client with	n of aggression between					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 7 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G116	B. WIN	G		05/16/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					FFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		LOWEL	L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	involving any kind of					
	· · · · · · · · · · · · · · · · · · ·	derogatory terminology					
		lume of speech or					
	l * *	13 behavior plan also					
		44 demonstrated physical					
	aggression defin	ed as "includes but not					
	1	, kicking, grabbing,					
	shoving or the us	se of an object as a					
	weapon to attem	pt to intentionally cause					
	harm to others."	Client #4's behavior plan					
	indicated others	should be removed from					
	the area when cl	ent #4 demonstrated					
	physical aggress	ion. The plan indicated					
	staff was to tell of	elient #4 "his actions					
	are inappropriate	and that talking is a					
		tive way of dealing with					
	her (sic) problem	is" The plan also					
	` ' *	staff were to encourage					
		icipate in deep breathing					
	_	ses. The plan indicated					
		not calm down and					
	continued aggres	ssion, the least restrictive					
		rention techniques could					
	be used.	1					
	Client #4's 3/5/1	3 ISP and/or 3/13					
		oral Supports plan					
		ent's interdisciplinary					
		not meet to address the					
	` ′	of aggression between					
	clients #2 and #4						
	onents #2 and #4	·.					
	Interview with a	dministrative staff #1 and					
		ator (SC) #1 on 5/3/13 at					
	Service Coordina	ator (SC) #1 On 3/3/13 at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 8 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G116	(X2) MULTIPLE A. BUILDING B. WING	00	COM	e survey Pleted 6/2013
	PROVIDER OR SUPPLIER		STREE 1734	t address, city, state, zip (JEFFREY DR ELL, IN 46356	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	demonstrated ph Administrative s the incidents bet occurred at the d #1 indicated the would conduct the occurred at the d indicated she (SG and/or the nurse investigations if group home. Ad stated they would afterwards to eva or feel he is bein Administrative s not follow our pe the clients' IDTs the identified pat between the two The facility's pol reviewed on 5/2/ facility's 2/15/12 For Handling Ca Abuse indicated Indiana prohibits exploitation of o immediately rep- abuse, neglect of clients per agence The Arc Northw	taff #1 stated "No, we did blicy." SC #1 indicated did not meet to address stern of aggression clients. icy and procedures were 13 at 11:59 AM. The policy entitled Policy ses Of Neglect And "I. The Arc Northwest all abuse, neglect and ur clients. II. Staff will bort any allegations if exploitation of our y reporting procedure. est Indiana will meet y requirements for				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 9 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	,
ANDILAN	OF CORRECTION	15G116		LDING	00	05/16/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2010	
NAME OF I	PROVIDER OR SUPPLIEF	₹			EFFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE			L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	LETION ATE
TAG		buse, neglect, humiliation		IAG	,	DF	ATE.
	_	vill be investigated per the					
		ndiana's investigation					
	process, while p	•					
	individual"	Ü					
	2. The facility's	policy and procedures					
	were reviewed o	on 5/2/13 at 11:59 AM.					
	The facility's 2/1	15/12 policy entitled					
		lling Cases Of Neglect					
		cated "I. The Arc					
		na prohibits all abuse,					
		oitation of our clients. II.					
		diately report any					
	allegations if abo	_					
	-	our clients per agency					
		lure. The Arc Northwest					
		et current regulatory					
	_	reporting all incidents. ons of abuse, neglect,					
		xploitation will be					
		the Arc Northwest					
		gation process, while					
	protecting the in						
	proceeding and m						
	1. The facility f	ailed to report an					
	allegation of pos	ssible sexual abuse and an					
	incident of clien	t to client abuse					
	immediately to t	the administrator and/or to					
	the Division of I	Disability, Aging and					
	Rehabilitative So	ervices (DDARS)/BDDS					
	(Bureau of Deve	elopmental Disabilities					
	, ·	0 IAC 9-3-1 (b) (5) and to					
	Adult Protective	Services (APS) per IC					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 10 of 47

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G116	A. BUII B. WIN	LDING G		05/16/	2013
NAME OF P	PROVIDER OR SUPPLIER	1	1		ADDRESS, CITY, STATE, ZIP CODE		
					FFREY DR		
	NORTHWEST IND			l	L, IN 46356		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	12-10-3 for clier	nts #2, #4 and #5. Please				•	
	see W153.						
	2 The facility fa	ailed to conduct thorough					
	_	regard to client to client					
		gations of abuse, injuries					
		rce and/or incidents of					
	_	ent for clients #2, #4 and					
	#5. Please W15	4 .					
	3. The facility fa	ailed to put corrective					
	measures in plac	ee in regard to the					
	_	ns of aggression for					
	clients #2 and #4	4. Please see W157.					
	9-3-2(a)						
	()						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 11 of 47

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G116	(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE SU	URVEY
15G116	A. BUIL	DING	00	COMPLE	TED
	B. WING			05/16/2	013
	p. ,, i. (e		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			EFFREY DR		
ARC OF NORTHWEST INDIANA INC, THE			L, IN 46356		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, interview and record review for 2 of 13 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to report an allegation of possible sexual abuse and an incident of client to client abuse immediately to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for clients #2, #4 and #5. Findings include: 1. The facility's reportable incident reports, Incident/Accident (I/A) Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's 5/24/12 I/A indicated "[Client #4] reported to staff [female client] has been touching him inappropriately on van." The facility's reportable incident reports reviewed from 5/12 to 5/13 indicated the facility did not report the 5/24/12	W00	00153	An IDT meeting was held to investigate the incidents regarding clients #2 and #4 on 5/13/13. No abuse, neglect or exploitation was suspected du these incidents. Client # 5 will have an IDT by 6/10/13 to rule abuse, neglect or exploitation, modifications to his plan and recommendations will follow the meeting Corrective actions of the Behavior Plans for clients and #4 have been revised to indicate that both clients are to monitored for the remainder of the day following any aggressi. An IDT meeting will occur with 24 hours of any episode of client aggression to determ if abuse, neglect, or exploitation occurred. Protective measures will be put into place to ensure safety of all clients following aggression. To ensure future compliance, posters explaining client rights and reporting requirements were distributed all group homes and the day program so that staff and client become more aware of the requirements on an ongoing basis. Additionally all staff will trained on reporting and investigation requirements for	ring ring ring rout solution solution solution solution to to to	06/10/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 12 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		15G116		LDING	-	05/16/	2013
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL NA/FOE IND	IANIA INIO TUE			FFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		LOWEL	L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	allegation of possible sexual abuse to				abuse, neglect, and exploitation	n	
	BDDS or APS.				at least annually unless chang		
	2225 011115.				occur or need requires this to		
	T.,,4 a.,,	dministrative staff #1 on			done more frequently. To ensu	ıre	
					that Service Coordinators are		
		M indicated he did not			trained on reporting and		
	locate a BDDS r	reportable incident report			investigation requirements for abuse, neglect (including the		
	for 5/24/12 incid	lent with client #4.			neglect of medical care),		
					exploitation and injuries of		
					unknown origin, the Behaviora	I	
					Health Director will review thei		
					training records at least annua	lly	
					and document review of finding		
					Area Managers will review DS		
					training records to ensure they	′	
					have been training at least	_	
					annually and document review	of	
					findings. All new Service		
					Coordinators and DSPs will be	;	
					trained on reporting and investigation requirements for		
					abuse, neglect (including the		
					neglect of medical care),		
					exploitation and injuries of		
					unknown origin prior to working	ga	
					home or with a client. In addit		
					the Service Coordinators will b	e	
					present in their homes at least		
					two times per month to ensure	!	
					protection of clients, address		
					concerns, monitor activities, et Documentation of visits will be		
					completed and will include		
					specifics to the client as well a	s	
					the visit. The Behavioral Heal		
					Director will review progress		
					notes regularly. To ensure futu	ıre	
					compliance, The Service		
					Coordinator will visit the clients		
					once a week at home and onc		
					week at the day services prog	ram	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 13 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED			
	15G116		A. BUILDING B. WING		05/16/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, TH	HE	STREET ADDRESS, CITY, STATE, ZIP CODE 1734 JEFFREY DR LOWELL, IN 46356					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PF REGULATORY OR LSC IDENTIFY)	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	2. A facility owned day pro	oram		for two months to ensure behavior plans are followed ar recommendations put in place are carried out. 6/14/13In add to the submitted plan, a syster for identifying and determining cause/effect and preventative approaches to incidents of client-to-client aggression will developed by 6/15/13. Client client aggression will be report to the administrator and BDDS applicable. If needed, an IDT meeting will be held to discuss modifications to the milieu, behavior plans, staff assignments, additional training or disciplinary measures, or of issues specifically relevant to client/s. Once developed, star will be trained on this system. The system will be monitored the Behavioral Health Director designee who will review incidereports involving client to client aggression to ensure system compliance. Changes will be made if necessary to the systems as needed to assure the effectiveness of the methodolo 6/21/13 While present, Service Coordinators and Managers was also monitor for client-to-client aggression, implementation of proactive and reactive measur of the behavior plan, providing active treatment, goal training community outings, and appropriate disposable of shall a	be to ted S as s.			
	=: 11 lacing of fied day pro-	0						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 14 of 47

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G116		(X2) MULTIPLE CO A. BUILDING	00	COM	E SURVEY PLETED 6/2012	
		106110	B. WING			6/2013
	PROVIDER OR SUPPLIER		1734 JE	ADDRESS, CITY, STATE, ZIP EFFREY DR L, IN 46356	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	from 10:00 A.M 10:10 A.M., clie work table. Clie table and stated, hear what I did? knife, and showe pointed to client thinks he's tough fight, he ain't tou "Yeah he pulled ain't tough." A review of the conducted at the office on 5/3/13 the facility's intereports indicated -Incident report clients told me that to talk to staff. I had pulled out a trip he told the dit again. [Client van and was smi himself, claimin When staff asked stated it was his, didn't want it to (Service Coordin instructed to ask leave him alone	conducted on 5/3/13 . until 11:05 A.M. At nt #5 was seated at a ent #2 walked to the work to this surveyor "Did you I pulled out a pocket ed it." Client #2 then #5 and began saying "He et, he don't know how to eigh." Client #5 then said out a knife, he's weak, he facility's records was facility's administrative at 12:05 P.M. Review of rnal Incident/Accident et the following: dated 5/1/13: "The ent the bus driver wanted et said that [client #2] 2 inch knife during the river he 'maybe' won't do #2] came outside to the ling and looking proud of g he didn't do anything. It is and be taken awayThe SC entor) was called, she him for the knife and otherwise. He was in for it by midafternoon				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 15 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	
		15G116	B. WI			05/16/	2013
NAME OF T		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF E	PROVIDER OR SUPPLIE	R		1734 JE	FFREY DR		
	NORTHWEST IND	·		LOWEL	L, IN 46356		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` *	e, don't take it to					
	workshop) but (didn't give it to staff till					
	late in the even	ing. He wrapped it heavily					
	in paper and tar	e and wrote his name.					
		d it to verify it really was a					
		folding knife with a 2 inch					
		ed edge. It looks easily					
		No documentation was					
		eview to indicate the					
		ately reported the incident					
	1	ator and other officials					
		ator and other officials					
	(BDDS/APS).						
	An interview w	ith the Service (SC) was					
		e facility's administrative					
		at 12:15 P.M. The SC					
		was no evidence available					
		dicate this incident was					
	_	liately to the administrator					
		of Developmental					
	Disabilities Ser	vices (BDDS).					
	9-3-2(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 16 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		15G116	B. WIN			05/16/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			LL, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.420(d)(3) STAFF TREATMI The facility must be alleged violations investigated. Based on observer record review for abuse, client to compare and/or injuries of reviewed, the fact thorough investigated to client aggressi injuries of unknown incidents of neglements and the fact thorough investigated to client aggressi injuries of unknown incidents of neglements and the fact thorough investigated to client aggressi injuries of unknown incidents of neglements and the fact that the facility's reports, internal in the facility's reports, internal in the facility's 3/12/13 report indicated the workshop manage could not find [compared to the staff search their building. Staff and staff search their building. Staff and staff search the staff search the staff search the staff search the staff search staff search the staff search staf	ENT OF CLIENTS have evidence that all are thoroughly ation, interview and r 11 of 13 allegations of lient abuse, neglect f unknown source cility failed to conduct gations in regard to client on, allegations of abuse, own source and/or ect/elopement for clients : reportable incident Incident/Accident (I/A) nvestigations were 13 at 11:53 AM. The reportable incident 'Staff informed ger at 12:20 pm that she lient #2]. Staff paged front office and had all	W0		CROSS-REFERENCED TO THE APPROPRIAT	ring e out nis f #2 o be f on. in ent ine on s e the	
neighborhood while center staff continued to look on site. Emergency services were called @ (at) 12:43 and arrived @ 12:55				basis. Additionally all staff will trained on reporting and investigation requirements for Abuse Neglect, and Exploitation			
	•	re stating they would eaking with emergency			at least annually unless chang occur or need requires this to	es	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 17 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G116	B. WIN			05/16/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC. THE			L, IN 46356		
					, 10000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	, ,	Manager joined in a			done more frequently. To ensu	ıre	
	vehicle search.	Staff in vehicles kept in			that Service Coordinators are trained on reporting and		
	contact via cell p	ohones along with			investigation requirements for		
	maintaining cont	tact with center. At 1:23			abuse, neglect (including the		
	_	nager stated she had a			neglect of medical care),		
	-	#2] and was at the			exploitation and injuries of		
	-	-			unknown origin, the Behaviora		
		ome in Lowell. She asked			Health Director will review thei		
		wanted to come back in			training records at least annua	•	
	her vehicle to ret	turn to the center. [Client			and document review of finding	_	
	#2] took off a se	cond time and entered the			Area Managers will review DS		
	[name of restaur	ant] stating he wanted to			training records to ensure they	1	
	_	m when he came out he			have been training at least annually and document review	of	
	_	nt out the side door and			findings. All new Service	Oi	
	1				Coordinators and DSPs will be		
	_	n. The [name of town]			trained on reporting and		
	emergency made				investigation requirements for		
	surrounding com	nmunities and @ 1:30 the			abuse, neglect (including the		
	County sheriff as	nd (sic) arrived to assist			neglect of medical care),		
	the Facility Man	ager. After emergency			exploitation and injuries of		
		with [client #2] he			unknown origin prior to working		
		ner vehicle and was			home or with a client. In additi		
					the Service Coordinators will b		
		to the center" The			present in their homes at least two times per month to ensure		
	-	reportable incident			protection of clients, address		
	_	client #4 was seen eating			concerns, monitor activities, et	c.	
	lunch at 12:05 P	M, and had a one staff to			Documentation of visits will be		
	10 client ratio.	The 3/12/13 reportable			completed and will include		
		id not indicate any			specifics to the client as well a		
	additional inforn	-			the visit. The Behavioral Heal	th	
					Director will review progress		
		n investigation had been			notes regularly. To ensure futu	ire	
	conducted.				compliance, The Service	,	
					Coordinator will visit the clients once a week at home and once		
	Interview with a	dministrative staff #1 on			week at the day services progr		
	5/3/13 at 3:10 PM	M indicated the incident			for two months to ensure	uiii	
	occurred at the fa	acility owned day service			behavior plans are followed an	ıd	
		nistrative staff #1			recommendations put in place		
	Program. Admin	iistiative stail ir l			. ,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 18 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	TED
		15G116				05/16/2	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODTHWEST IND	IANIA INIO TUE			FFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		LOWEL	L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the fac	ility did not conduct an			are carried out. 6/14/13In addi		
	investigation in i	regard to the 3/12/13			to the submitted plan, a syster		
	elopement incide				for identifying and determining		
	eropement meta	ont.			cause/effect and preventative		
	0 TPL - C - :114 1-				approaches to incidents of client-to-client aggression will	ho	
	_	reportable incident			developed by 6/15/13. Client to		
		Incident/Accident			client aggression will be report		
	•	nvestigations were			to the administrator and BDDS		
	reviewed on 5/2/	/13 at 11:53 AM. The			applicable. If needed, an IDT		
	facility's reportal	ble incident reports, I/A			meeting will be held to discuss	3	
	reports and/or in	vestigations indicated the			modifications to the milieu,		
	following:				behavior plans, staff		
	Tollowing.				assignments, additional trainin		
	1/11/12 [0]:	// 43.1 11: ·			or disciplinary measures, or ot		
	_	#4] began yelling at			issues specifically relevant to t client/s. Once developed, staf		
		g that [client #2] could			will be trained on this system.	'	
	not tell him wha	t to do. [Client #2] then			The system will be monitored I	by	
	pushed [client #4	4] which made [client #4]			the Behavioral Health Director	-	
	fall backwards o	onto his buttocks." The			designee who will review incid	ent	
	I/A indicated clic	ent #4 was not injured.			reports involving client to clien	t	
	1/11 IIIaicaica cii	one with was not injured.			aggression to ensure system		
	10/21/12 #[@]:-				compliance. Changes will be		
	_	nt #2] was talking with			made if necessary to the syste	em	
	_	4] said 'shut up' to [client			as needed to assure the		
		then hit him (client #4)			effectiveness of the methodolo 6/21/13	ygy.	
	and started yelling	ng. Staff separated,			While present, Service		
	redirected and to	old him that is not			Coordinators and Managers w	ill	
		e 10/12/12 I/A indicated			also monitor for client-to-client		
	client #4 was no				aggression, implementation of		
	onone na was no	· mjarou.			proactive and reactive measur	es	
	10/20/12# [61:				of the behavior plan, providing		
	-	nt #2] was singing			active treatment, goal training,		
		[Client #4] got irritated			community outings, and		
	and told [client #	#2] to shut up while using			appropriate disposable of shar	ps.	
	profanity and sm	nacked [client #2] on his					
	back." The I/A	report indicated client #2					
	was not injured.	•					
	, as not injured.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 19 of 47

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G116	B. WIN			05/16/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST INC	NANA INC. THE			FFREY DR L, IN 46356		
					L, IIV 40330		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		clients (clients #2 and		-			
		ed on arrival & (and) staff					
	, ,	stay separate & calm					
		4 walked over into the					
	_	2] approached him saying					
		be like that & [client #4]					
		client #2) and fight insued					
	· ·	ing more arm slapping."					
		ed clients #2 and #4 were					
	not injured.						
	-9/28/12 '[Clien	t #4] hit [client #2] on his					
	(R) (right) shou	lder." The I/A report					
	indicated client	#4 was redirected. The					
	I/A report indica	ated client #2 was not					
	injured.						
	The above ment	cioned I/A reports of client					
	to client aggress	sion/abuse indicated the					
	facility did not of	conduct an investigation in					
	regard to the inc	eidents of					
	aggression/abus	e.					
	Interview with a	administrative staff #1 and					
		nator (SC) #1 on 5/3/13 at					
		ted clients #2 and #4					
	_	nysical aggression.					
		staff #1 indicated most of					
		tween clients #2 and #4					
		day service program. SC					
		day service program					
		the investigations if they					
		day program. SC #1					
	indicated she (S	C #1), administrative staff					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 20 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		15G116	B. WIN			05/16/	2013
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	S.			EFFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE			L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and/or the nurse	would conduct the					
	investigations if	they occurred at the					
	group home. Ac	Iministrative staff stated					
	1 ~ ^	et as a group afterwards to					
	I -	s an abuser or feel he is					
		Administrative staff #1					
		id not follow our policy."					
	siaicu No, we u	id not follow out policy.					
	3. The facility's	reportable incident					
	I -	/Accident Reports and/or					
		ere reviewed on 5/2/13 at					
		facility's 5/24/12 I/A					
		nt #4] reported to staff					
	_	as been touching him					
		on van." The 5/24/12 I/A					
		beers who rode the van					
		er were interviewed. The					
		de the names of others					
		iewed and/or the witness					
		e interviews. The I/A					
		#4 indicated the female's					
	touching had occ	curred on other occasions.					
	The I/A indicate	d client #4 was					
	encouraged to re	port when the incidents					
	occurred. The I/	A did not indicate any					
		nentation/evidence of an					
	investigation.						
	<i>3</i>						
	Interview with a	dministrative staff #1 on					
		M stated "It does not look					
	like an investiga						
	inc an investiga	non was done.					
	4. The facility's	reportable incident					
	· ·	/Accident Reports and/or					
,	l • ´	*	L				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 21 of 47

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
		15G116	A. BUI B. WIN	LDING		05/16/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				FFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		LOWEL	L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ere reviewed on 5/2/13 at		1710	·		DATE
	_	facility's 5/6/12 I/A					
		"Staff noticed [client					
	•	e scabbed and scratched					
	up on both sides	. Client tried to hide it."					
	The I/A indicate	d staff cleaned the areas					
		le Antibiotic ointment to					
		'A indicated "Cause is					
		is unable to tell us"					
		icated "Nurse spoke					
		at) workshop. He stated ching himself on &					
		" The 5/6/12 I/A did					
		staff and/or clients were					
	-	egard to the 5/6/12					
	incident.	<i>O</i>					
	Interview with a	dministrative staff #1 on					
		M indicated no additional					
	information/ inv	•					
	documented on t	the I/A.					
	5 The facility	ranartable incident					
	-	reportable incident /Accident Reports and/or					
	_	ere reviewed on 5/2/13 at					
	•	facility's reportable					
		the Incident/Accident					
	_	nvestigations indicated					
	the following:	-					
	_	#4] was upset with [client					
		a chair & he (client #4)					
		The I/A report indicated					
	client #5 was no	t injured.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 22 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G116	B. WIN	G		05/16/	2013
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIO TUE			FFREY DR		
	NORTHWEST IND	·		LOWEL	L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	CESC IDENTIFYING INFORMATION)		TAG	DLI ICILIACT)		DATE
	0/20/12 !!Di	- 1					
	l '	g lunch, [client #4]					
		ecause [client #5] walked					
	_	4's] chair on his way to					
		nway, and [client #4]					
		[client #5] two times,					
		shoulder, and once on his					
	` ′	e I/A indicated client #5					
	was not injured.						
	The C/C/10 and C	0/20/12 1/4 - 1:1 4					
		9/28/12 I/As did not					
		lity conducted an					
		regard to the client to					
	client abuse/agg	ression incidents.					
	I	dministrative staff #1 on					
	5/3/13 at 3:10 P						
	_	s conducted in regard to oned client to client					
	incidents.	oned chefit to chefit					
	_	ned day program conducted on 5/3/13					
		I. until 11:05 A.M. At					
	· · · · · · · · · · · · · · · · · · ·	ent #5 was seated at a					
		ent #2 walked to the work					
	1	to this surveyor "Did you					
		I pulled out a pocket					
		ed it." Client #2 then					
	_	#5 and began saying "He					
		n, he don't know how to					
	•	agh." Client #5 then said					
		d out a knife, he's weak,					
	he ain't tough."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 23 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		15G116		LDING		05/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST IND	ANA INC, THE		LOWEL	L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DETCIENCT)		DATE
		facility's records was facility's administrative					
		at 12:05 P.M. Review of					
		rnal Incident/Accident					
	reports indicated						
	-Incident report	dated 5/1/13: "The					
	clients told me th	nat the bus driver wanted					
	to talk to staff. I	He said that [client #2]					
	•	2 inch knife during the					
	-	river he 'maybe' won't do					
		#2] came outside to the					
		ling and looking proud of					
	· ·	g he didn't do anything.					
		d him for the knife, he					
	-	he didn't steal it and					
		be taken awayThe SC nator) was called, she					
	`	him for the knife and					
		otherwise. He was					
		n for it by midafternoon					
	(keep it at home,						
	` •	idn't give it to staff till					
	late in the evenir	ng. He wrapped it heavily					
	in paper and tape	e and wrote his name.					
	Staff unwrapped	it to verify it really was a					
		olding knife with a 2 inch					
		ed edge. It looks easily					
		o documentation was					
	submitted to indi						
		orted the incident to the					
	administrator and	d other officials.					
	An interview with	th the Service (SC) was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 24 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G116	A. BUII	LDING	00	COMPLETED 05/16/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR		
	NORTHWEST INDI	<u> </u>			L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		facility's administrative		IAG			DATE
		at 12:15 P.M. The SC					
	indicated there w						
		vailable for review to					
		gh investigation was					
		ard to this incident.					
	_	n investigation had been					
		C stated "I didn't know					
		investigation." When					
		driver, [client #5] or any					
		he van were interviewed,					
	the SC stated, "N	Io. I didn't think we could					
	interview the oth	er clients and I didn't					
	interview [client	#5]." No documentation					
	was submitted to	indicate a thorough					
	investigation had	been conducted.					
	9-3-2(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 25 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		15G116	B. WIN			05/16/2013	
					ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	PROVIDER OR SUPPLIER	L.			EFFREY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE			L, IN 46356		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	N
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W000157	483.420(d)(4)	ENT OF OUENTO					
		ENT OF CLIENTS					
	If the alleged violation is verified, appropriate corrective action must be taken.						
		ew and record review for	l wo	00157	An IDT meeting was held to	06/10/201	13
			"	00137	investigate the incidents	00/10/201	١٥
	_	ns of abuse, neglect			regarding to clients #2 and #4		
		f unknown source			5/13/13. No abuse, neglect or		
		cility failed to put			exploitation was suspected du	• 1	
	corrective measu	ires in place in regard to			these incidents. Client # 5 will	•	
	the identified par	tterns of aggression for			have an IDT by 6/10/13 to rule	out	
	clients #2 and #4	l .			abuse, neglect or exploitation modifications to his plan and		
					recommendations will follow th	uis	
	Findings include:				meeting. Corrective actions of		
					the Behavior Plans for clients		
	The facility's ren	ortable incident reports,			and #4 have been revised to		
		/Accident (I/A) Reports			indicate that both clients are to		
		` ′ •			monitored for the remainder of		
		tions were reviewed on			the day following any aggressi An IDT meeting will occur with		
		AM. The facility's			24 hours of any episode of clie		
	_	ent reports, I/A reports			on client aggression to determ	•	
	and/or investigat	tions indicated the			if abuse, neglect, or exploitation		
	following:				occurred. Protective measures	i	
					will be put into place to ensure	the	
	-1/11/13 [Client	#4] began yelling at			safety of all clients following		
	[client #2] saving	g that [client #2] could			aggression. To ensure future	,	
] ' ' '	t to do. [Client #2] then			compliance, posters explaining client rights and reporting	'	
		4] which made [client #4]			requirements were distributed	to	
	^ ~	nto his buttocks." The			all group homes and the day		
		ent #4 was not injured.			program so that staff and clien	ts	
		_			become more aware of the		
		d "Bx (behavior) Plan			requirements on an ongoing	h	
		ss aggression. Plan			basis. Additionally all staff will trained on reporting and	be	
		Il be effective incidents			investigation requirements for		
	within normal ra	nge"			Abuse Neglect, and Exploitation	on	
					at least annually unless chang	•	
	-10/21/12 "[Clie	nt #2] was talking with			occur or need requires this to	oe e	
		4] said 'shut up' to [client			done more frequently. To ensu	ıre	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 26 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G116	B. WIN			05/16/2013	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLET	ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	#2]. [Client #2]	then hit him (client #4)			that Service Coordinators are		
	and started velling	ng. Staff separated,			trained on reporting and		
		old him that is not			investigation requirements for		
		e 10/12/12 I/A indicated			abuse, neglect (including the		
					neglect of medical care), exploitation and injuries of		
		t injured. The I/A report			unknown origin, the Behaviora		
		ents were separated and			Health Director will review thei		
		further aggression.			training records at least annua		
	None occurred.	Behavior plans			and document review of finding	gs.	
	followed"				Area Managers will review DS		
					training records to ensure they		
	-10/20/12 "[Clie	nt #2] was singing			have been training at least		
	_	[Client #4] got irritated			annually and document review	of	
		2] to shut up while using			findings. All new Service Coordinators and DSPs will be		
	-	, ,			trained on reporting and		
		acked [client #2] on his			investigation requirements for		
		report indicated client #2			abuse, neglect (including the		
	was not injured.	The 10/20/12 I/A			neglect of medical care),		
	indicated the clie	ents were separated and			exploitation and injuries of		
	monitored for fu	rther aggression. The I/A			unknown origin prior to working		
	report indicated	"Behavior Plans			home or with a client. In addit		
	followed."				the Service Coordinators will be present in their homes at least		
	10110 11 041				two times per month to ensure		
	10/12/12 "Doth	aliants (aliants #2 and			protection of clients, address		
		clients (clients #2 and			concerns, monitor activities, et	с.	
	'	d on arrival & (and) staff			Documentation of visits will be		
		stay separate & calm			completed and will include		
	_	4] walked over into the			specifics to the client as well a		
	area & [client #2	approached him saying			the visit. The Behavioral Heal	n	
	why you have to	be like that & [client #4]			Director will review progress notes regularly. To ensure futu	re	
	went after him (c	client #2) and fight insued			compliance, The Service		
	`	ng more arm slapping."			Coordinator will visit the clients		
		d clients #2 and #4 were			once a week at home and onc		
		I/A report indicated			week at the day services progr	am	
		•			for two months to ensure		
	client #2 and #4'	•			behavior plans are followed ar	d	
	addressed aggres	ssion.			recommendations put in place	:	
					are carried out. 6/14/13In addi	ion	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 27 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED
		15G116		LDING		05/16/2013
			B. WIN		DDDFGG CITY CTATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
ADC 05	NODTHWEST IND	IANIA INIC. THE			EFFREY DR	
ARC OF	NORTHWEST INDI	ANA INC, THE		LOWEL	L, IN 46356	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	-9/28/12 "[Client	t #4] hit [client #2] on his			to the submitted plan, a syster	
	(R) (right) should	der." The I/A report			for identifying and determining	
	indicated client #	#4 was redirected. The			cause/effect and preventative	
		ted client #2 was not			approaches to incidents of client-to-client aggression will	he
	injured.	ted effett #2 was flot			developed by 6/15/13. Client	
	injurcu.				client aggression will be report	
		1.7/4			to the administrator and BDDS	
		oned I/A reports			applicable. If needed, an IDT	
		ility failed to put			meeting will be held to discuss	;
	corrective measu	res in place which			modifications to the milieu,	
	address the targe	eted incidents of			behavior plans, staff	
	aggression between	een the clients.			assignments, additional trainin	<u> </u>
					or disciplinary measures, or ot issues specifically relevant to t	
	Interview with a	dministrative staff #1 and			client/s. Once developed, staf	
		ator (SC) #1 on 5/3/13 at			will be trained on this system.	
		* *			The system will be monitored I	ру
		ed clients #2 and #4			the Behavioral Health Director	
		ysical aggression.			designee who will review incid	l l
	Administrative s	taff #1 indicated most of			reports involving client to clien	t
	the incidents bet	ween clients #2 and #4			aggression to ensure system	
	occurred at the d	ay service program. SC			compliance. Changes will be made if necessary to the syste	am
	#1 indicated the	day service program			as needed to assure the	111
		ne investigations if they			effectiveness of the methodolo	ogv.
		ay program. SC #1			6/21/13	37
		$\mathbb{C} \# 1$), administrative staff			While present, Service	
	`	**			Coordinators and Managers w	
		would conduct the			also monitor for client-to-client	l l
		they occurred at the			aggression, implementation of	
	1 ~ ^	lministrative staff stated			proactive and reactive measur of the behavior plan, providing	l l
	they would "mee	et as a group afterwards to			active treatment, goal training,	
	evaluate if one is	s an abuser or feel he is			community outings, and	
	being abused."	Administrative staff #1			appropriate disposable of shar	ps.
	_	id not follow our policy."			•	
	·	the clients' IDTs did not				
		the identified pattern of				
	aggression between	een the two clients.				
			1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 28 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G116	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	PLETED 6/2013
	PROVIDER OR SUPPLIER		STREET A 1734 JE	ADDRESS, CITY, STATE, ZI EFFREY DR .L, IN 46356	P CODE	
ARC OF (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	IANA INC, THE TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			N SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 29 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G116	B. WIN			05/16/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			1734 JE	EFFREY DR	
	NORTHWEST INDI	ANA INC, THE			L, IN 46356	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W000240	483.440(c)(6)(i) INDIVIDUAL PRO	CDAM DI ANI				
		ogram plan must describe				
	relevant interventions to support the					
	individual toward					
	Based on observ	ation, interview and	W0	00240	This client's Behavior Plan has	06/15/2013
	record review for	r 1 of 3 sampled clients			been updated to reflect	
		Individual Support Plan			monitoring procedures to previous	
	` ' '	avior plan failed to			elopement, specific definitions the physical techniques have a	
		eate how facility staff			been added. The plan previou	
	1 2	the client to prevent			stated that this client was not t	•
	elopement from	-			be left alone while upset. Day	
	cropement from	ine day program.			Services staff will be retrained	to
	T				provide proper supervision to	_
	Findings include	:			monitor this client by 6/15/13. ensure future compliance, the	10
					service coordinator will collect	
		ortable incident reports,			data from the various sites of	
		Accident (I/A) Reports			service and will summarize it o	n a
	_	ions were reviewed on			monthly basis. The Behaviora	
	5/2/13 at 11:53 A	AM. The facility's			Health Director will audit these	;
	3/12/13 reportab	le incident report			summaries monthly until proficiency has been establish	od
	indicated "Staff i	informed workshop			and then will fade to periodic	eu
	manager at 12:20) pm that she could not			audits. Adjustments will be ma	ade
	find [client #2].	Staff paged [client #2] to			and training will take place who	ere
		nd had all staff search			necessary.6/14/13The service	
		the building. Staff			coordinator will observe client	and
		shop manager left in their			staff at the day program and home on a weekly basis to	
		h the neighborhood while			ensure that preventative	
		nued to look on site.			measures are being implemen	ts
		ces were called @ (at)			on a regular basis. Once	
		d @ 12:55 to obtain a			proficiency in implementation	
		\circ			the plan is established monitor visits will reduce to two times p	
		ey would return. After			month. 6/21/13) C I
	1 0	nergency services,			While present, Service	
		r joined in a vehicle			Coordinators and Managers w	ill
		vehicles kept in contact			also monitor for client-to-client	
	via cell phones a	long with maintaining			aggression, implementation of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 30 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G116	(X2) MU A. BUIL B. WING	DING	onstruction 00	(X3) DATE S COMPL 05/16/	ETED
	PROVIDER OR SUPPLIER			1734 JE	ADDRESS, CITY, STATE, ZIP CODE EFFREY DR L, IN 46356		
					.L, IIV 40000		715
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	contact with cent Manager stated stated stated stated stated stated stated stated to come return to the cent second time and restaurant] stating restroom when he immediately were headed East againg emergency mades surrounding come County sheriff at the Facility Manapersonnel spoke willingly got in heading the stated area will be main staff working are [client #2] will be of the cafeteria was proximity of the area" The 3/1 indicated the day put in place corresponding to manager the stated the day put in place corresponding to manager the stated the day put in place corresponding to manager the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the day put in place corresponding to monitoring the stated the	ter., At 1:23 pm, Facility she had a visual on [client he Jeffery Group home in he		IAG	proactive and reactive measure of the behavior plan, providing active treatment, goal training community outings, and appropriate disposable of sharest control of the property of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment, goal training community outings, and appropriate disposable of sharest control of the providing active treatment and the providing active treatment active treatment and the providing active treatment) ,	DATE
	110111 10.00 A.M	until 11:10 A.M. During					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 31 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15G116	B. WIN			05/16/	2013
			D. (122		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIEF	2			FFREY DR		
ARC OF	NORTHWEST IND	IANA INC, THE			L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	ì ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ration period, client #2					
		at of the workshop area					
		•					
	_	at 11:00 A.M., day					
	program DSP (D	* *					
	· · · · · · · · · · · · · · · · · · ·	walked over to DSP #6					
		re is [client #2]?" Both					
		and trying to find client					
		ding at the back of the					
	workshop lookir	ng at books in a box.					
	Client #2's recor	d was reviewed on 5/2/13					
	at 3:39 PM. Clie	ent #2's 3/13 Behavior					
	Plan indicated cl	ient #2 had a history of					
	elopement. Clie	nt #2's 3/13 behavior plan					
	indicated client	#2 had eloped from the					
		nys in a row in January					
		vior plan also indicated					
		lefined as "[Client #2]					
		e from a situation where					
		r threatened" Client					
	#2's 3/13 behavior						
		cate how facility staff					
		the client at the group					
		• •					
		he day program to					
	prevent client #2	thom eloping.					
		ervice Coordinator (SC)					
		3:10 PM stated client #2					
	_	upset or told something					
		" When asked how client					
		ed to prevent elopements,					
	SC #1 stated "He	e has proactive measures					
	in his plan."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 32 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G116	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	PLETED 6/2013
	PROVIDER OR SUPPLIER		STREET A 1734 JE	ADDRESS, CITY, STATE, ZI EFFREY DR .L, IN 46356	P CODE	
ARC OF (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			N SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 33 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G116	B. WIN			05/16/	2013
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000249	483.440(d)(1) PROGRAM IMPL As soon as the in formulated a clier each client must it treatment prograr interventions and number and frequ achievement of the the individual profit Based on observing record review for (#1) and for 2 and #5), the facility for clients' program opportunities for Findings include An evening obset the group home of until 7:00 P.M. 7:00 P.M., client living room with Direct Support P would check on offer any meaning stayed in the offit inventory and dis meaningful active #5. A review of client conducted on 5/3 Individual Support	EMENTATION terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient tency to support the ne objectives identified in gram plan. ation, interview and in 1 of 3 sampled clients ditional clients (#4 and failed to implement the plan objectives when in training existed. Exercise training existed. Exercise training existed. Exercise training existed at in the interview and in the plan objectives when in training existed. Exercise training existed at in the interview and in the plan objectives when in training existed. Exercise training existed at in the interview and in the plan objectives when in training existed. Exercise training existed at in the interview and in the plan objectives when in training existed. Exercise training existed at in the interview and in the plan objectives when it is a plan objective w	W0	00249	All staff will be retrained on implementing the client's IPP, providing active treatment and importance of community activities on an ongoing basis 6/15/13. To ensure future compliance, The Service Coordinator will visit the home once a week for 2 months and bimonthly thereafter to ensure that active treatment is taking place. The Service Coordinator will also review client activity to ensure the clients are all be taken out into the community. 6/14/13The service coordinator will collect data from the day program and residential location weekly for 4 weeks and then we fade to monthly once proficien has been established. The Coordinator will summarize the data and analyze the summarileast monthly to ensure conting growth in goal areas. 6/21/13 While present, Service Coordinators and Managers we also monitor for client-to-client aggression, implementation of proactive and reactive measur of the behavior plan, providing active treatment, goal training,	by or ogs ing on vill cy e y at ued	06/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 34 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G116	B. WIN			05/16/20)13
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					FFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		LOWEL	L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		e been implemented			community outings, and appropriate disposable of sha	rne	
		3 observation period:			appropriate disposable of sital	193.	
		lect amount to subtract					
		ingWill write/recite his					
		ent telephone number and					
	1	inGiven a random					
		e settings, will tell time					
	correctly."						
		nt #4's record was					
	conducted on 5/3	3/13 at 3:45 P.M. A					
	review of client	#4's ISP dated 3/5/13					
	indicated the foll	lowing objectives which					
	could have been	implemented during the					
	5/1/13 observation	on period: "Will walk 5					
	days a week for	15 minutesWill					
	continue to recor	d entry on his budget					
		hat are received or spent					
		ill learn to fold his					
	clothes when lau	ndry is completeWill					
	learn to zip and l	_					
	r						
	A review of clies	nt #5's record was					
		3/13 at 3:15 P.M. A					
		#5's ISP dated 3/6/13					
		lowing objectives which					
		implemented during the					
		on period: "Will wear his					
		day at homeWill					
	1 ~	ove his communication					
	through utilizing	_					
		inue to improve his					
		nent skills by learning to					
	work on balancii	ng his budget and writing				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 35 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G116	A. BUILDING B. WING	00	COMP 05/16	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	1734 JE	ADDRESS, CITY, STATE, ZIP EFFREY DR .L, IN 46356	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAG	items on budget sheet with amount." The Service Coordinator (SC) was interviewed on 5/9/13 at 1:25 P.M. The SC indicated active treatment should be ongoing and training objectives should be implemented at all times of opportunity. 9-3-4(a)	TAG	DEFICIENCY)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 36 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G116		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE (COMPL 05/16 /	ETED	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STR 173	34 JEF	DDRESS, CITY, STATE, ZIP CODE FFREY DR -, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W000289	BEHAVIOR The use of syster manage inappropion be incorporated in program plan, in a §483.440(c)(4) ar Based on intervirulation of 3 sampled conditional client specify the type of interventions where each client. Findings include Client #2's record at 3:39 PM. Client Plan (B/P) indicated demonstrated phosphore was defined as "lobjects when any hitting others, or open or closed his behavior plan incomplete indicated facility the client to partitle indicated facility the client to partitle indicated in the system indicated facility the client to partitle indicated in the system in the client to partitle indicated in the system in the client to partitle indicated in the system in the client to partitle in the system in the system in the client to partitle in the client in the system in the system in the system in the client in the system in the sy	and (5) of this subpart. ew and record review for dients (#2) and for 1 (#4), the facility failed to of restraints/behavioral ich could be utilized with d was reviewed on 5/2/13 ent #2's 3/13 Behavior	W00028		This client's Behavior Plan has been updated to reflect monitoring procedures to prevelopement, specific definitions the physical techniques have a been added. The plan previous stated that this client was not to be left alone while upset. Day Services staff will be retrained provide proper supervision to monitor this client by 6/15/13. ensure future compliance, the service coordinator will collect data from the various sites of service and will summarize it comonthly basis. The Behavioral Health Director will audit these summaries monthly until proficiency has been establish and then will fade to periodic audits. Adjustments will be may and training will take place whencessary. The service coordinator will observe client staff at the day program and home on a weekly basis to ensure that preventative measures are being implement on a regular basis. Once proficiency in implementation of the plan is established monitor visits will reduce to two times promoth. 6/21/13 While present, Service	ent of also usly o to To on a al e ed ade ere and tts of	06/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 37 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL	
THIND I LIMIT	or conduction	15G116	1	LDING		05/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30, 10,	
NAME OF F	PROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		gression continues utilize		1110	Coordinators and Managers w	/ill	DITTE
		ve NICE (Non-Violent			also monitor for client-to-client	t	
	Intervention for	· ·			aggression, implementation of proactive and reactive measure		
	Empowerment) t	techniques necessary to			of the behavior plan, providing		
		of [client #2] and			active treatment, goal training		
	others" Client	t #2's 3/13 BP did not			community outings, and appropriate disposable of sha	rne	
		ific techniques the staff			appropriate disposable of sila	ιρδ.	
		lient #2 when he was					
	physically aggre	ssive.					
	Client #1/s recor	d was reviewed on 5/3/13					
		ent #4's 3/13 Positive					
		orts indicated client #4					
	* *	rbal aggression defined as					
		t limited to verbal threats,					
		involving any kind of					
	harm, the use of	derogatory terminology					
	and increased vo	lume of speech or					
	yelling." The 3/	13 behavior plan also					
		#4 demonstrated physical					
		ed as "includes but not					
	_	, kicking, grabbing,					
	_	se of an object as a					
		pt to intentionally cause					
		Client #4's behavior plan should be removed from					
		ient #4 demonstrated					
		ion. The plan indicated					
		client #4 "his actions					
		e and that talking is a					
		etive way of dealing with					
		ns" The plan also					
		staff were to encourage					
	the client to part	icipate in deep breathing					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 38 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G116		A. BUILDING B. WING	00	COMPI 05/16.	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	1734 JE	ADDRESS, CITY, STATE, ZIP C EFFREY DR .L, IN 46356	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE , DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	relaxation exercises. The plan indicated "If physical aggression continues utilize the least restrictive MANDT (physical intervention techniques) techniques necessary to ensure [client #4's] safety and the safety of others" Client #4's 3/13 behavior plan did not indicate the specific techniques the staff could use with client #4 when he was physically aggressive. Interview with administrative staff #1 and Service Coordinator (SC) #1 on 5/3/13 at 3:10 PM indicated they were not aware the clients' behavior plans needed to include the specific techniques staff could use with the clients. 9-3-5(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 39 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETER			ETED	
		15G116	B. WIN			05/16/	2013
			D. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				EFFREY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000436	483.470(g)(2) SPACE AND EQ						
		furnish, maintain in good					
	•	clients to use and to make					
	eyeglasses, hear	about the use of dentures,					
		aids, braces, and other					
		by the interdisciplinary					
	team as needed l						
	Based on observ	ation, record review, and	W0	00436	Client #3 will have a risk plan ı	put	06/15/2013
	interview, the fa	cility failed to assure the			in place in regards to his		
	repair of adaptiv	e equipment for 1 of 3			eyeglasses by 6/15/13 which v		
		who was prescribed			provide him with multiple promand documentation of these	ipts	
	eyeglasses and w	-			prompts throughout the day.		
		device (client #3).			Client #3 has regularly refused	d to	
	Communication	device (eneme 113).			wear his eye glasses for years		
	Findings include				and programming has proven		
	r manigs merade	•			ineffective. In addition Client #		
	A . 1				will have a visual assessment identify the functionality of his	to	
	•	ervation was conducted at			vision without modification. Th	ne	
		on 5/1/13 from 5:30 P.M.			results of this assessment will		
		During the observation			added to his plan.		
	•	was unable to articulate			Please note Correction to Clie	nt	
	*	y. Client #3 was not			#3 had an I POD for use for		
	observed utilizin	g a communication			communication. Client #3's I PAD is not meant to be a		
	device. During t	the entire observation			communication device. Guardi	ian	
	period client #3	did not and was not			has requested that client #3 no	ot	
	prompted to wea	r eyeglasses.			take his IPAD out of the house		
	•				any reason for fear of theft and	b	
	A review of clies	nt #3's record was			distraction from his job or programming. This request will	l bo	
		facility's administrative			obtained in writing by 6/15/13		
		at 3:00 P.M. Review of			will be revisited annually.	a. 14	
		l indicated a most current			Client #3 IPOD had a speaker		
	vision exam date				devise attached to it. Client #3		
					had year of training to use this		
		prescribed eyeglasses.			devise but prefers that people		
		t Individual Support Plan			to know him and speak to him		
	(ISP) dated 3/4/1	3 indicated: "[Client #3]			normally rather than through		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 40 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G116	A. BUILDING B. WING	00	COMPLETED 05/16/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	1734 JE	.ddress, city, state, zip code FFREY DR L, IN 46356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	wear his eyeglasses daily (sic)Speaking difficulties: Uses sign language, gestures, and has limited vocabulary but can speak some; has objective and uses an IPAD for communication." An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 5/9/13 at 1:25 P.M. The SC indicated staff should have prompted client #3 to wear his prescribed eyeglasses and to use his communication device. 9-3-7(a)		assistive technology. An appointment for Client #3 to se speech pathologist will be made by 6/15/13. When evaluated a alternative method of communication will be built into his plan. He has clearly chose to not use the I POD as a communication device.	ee a de an

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 41 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLI	ETED
		15G116	B. WIN			05/16/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				EFFREY DR			
ARC OF	NORTHWEST INDI	ANA INC, THE			L, IN 46356		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000454	483.470(I)(1) INFECTION CON	ITPOI					
		provide a sanitary					
	environment to a						
	transmission of in	fections.					
	Based on observ	ation, interview and	W0	00454	a new labeled sharps containe	er	06/15/2013
	record review for	r 1 of 2 sampled clients			was provided to the home on		
		failed to ensure the			5/3/13. The Service Coordina	tor	
		ff followed sanitary			will ensure that the sharps container is being used during		
		administering insulin.			weekly house visits for 2 mont		
		d to ensure sharps were			and bimonthly thereafter. The		
	disposed of properly/safely.				Service Coordinator will also		
disposed of property/sarcty.		criy/sarcry.			review incident reports which a	are	
	72' 1' ' 1 1				to be used to identify missing		
	Findings include	•			adaptive equipment. The world instruction of insulin injections		
	D : 11 5/0/1				be revised by 6/15/13 all staff		
	-	3 observation period			be trained on this plan by		
		M and 8:00 AM, at the			6/15/13. This training will inclu	ude	
		nt #1 checked his own			modeling and return		
	blood glucose le	vel. Once the client was			demonstration. Nurses in		
	done, the client s	tretched his arm back			conjunction with the Service Coordinator will observe staff		
	behind him and	dropped a lancet (sharp			administering subcutaneous		
	for blood draw for	or Glucometer/glucose			medication to ensure it is done	e in	
	monitor) into a g	rayish blue container			a sanitary manner initially and		
	, -	ocated behind a trash can			then weekly for week for 2	.	
	in the office area	. Client #1 did not use			months and bimonthly thereaft to ensure proficiency. The	ter	
	and/or staff #5 d	id not encourage the			Community Services Nurse wi	ill	
		his finger with an			also review all incident reports		
		or to sticking the client's			the home which document		
	_	eedle. The container was			medication errors. 6/14/13The		
	•				service coordinator will ensure		
	-	le (exposed sharps) and 6			that the sharps container is be used during weekly house visi		
	-	s were located on the			for 2 months and bimonthly	ıo	
		ntainer. Also, during the			thereafter. The Service		
		on period, staff #5			Coordinator in conjunction with	h	
	administered clie	_			the community service nurse v	will	
	medications. As	staff #1 was preparing to			also review requests from the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 42 of 47

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G116	B. WIN			05/16/2013
			1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	t .			FFREY DR	
	NORTHWEST IND				L, IN 46356	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	<u> </u>	DATE
		#1's insulin, staff #1			home to ensure that medical supplies like a sharps contained	2r
		from the insulin vial,			are consistently available.	
	1 ^	nto the vial and drew out			6/21/13While present, Service	
		needle. Staff #5 then			Coordinators and Managers w	
		shot/insulin into the			also monitor for client-to-client	
	back of client #1	's arm. Staff #5 did not			aggression, implementation of proactive and reactive measure	
	use an alcohol sv	wab to clean the insulin			of the behavior plan, providing	
	lid and/or use an	alcohol swab to sanitize			active treatment, goal training	
	client #1's arm/a	rea of arm prior to			community outings, and	
	administering th	e insulin. Staff #5 did not			appropriate disposable of share	rps.
	_	at any time prior and/or				
		re. Staff #5 did put				
		o administering the				
	insulin.	o wanning one				
	modilii.					
	The facility's un	dated Step by Step				
	I -	nistration of Insulin was				
		/13 at 1:45 PM. The				
		dicated facility staff were				
		-				
		s needed (insulin bottle,				
		swabs, gloves and sharps				
	Í	undated policy indicated				
	the following:					
	"3 Wash your	hands				
		id from the insulin bottle				
		asn't expired. Also check				
		edication ordered,				
	· · · · · · · · · · · · · · · · · · ·	f Administration and				
	Time ordered.	i i igillilisu autoli alia				
		har tan of the bettle with				
		ber top of the bottle with				
	an alcohol swab.					
		mmon places to inject				
	insulin are the al	odomen, the back of the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 43 of 47

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 05/16/2013
		15G116	B. WING		05/16/2013
NAME OF P	ROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC, THE		EFFREY DR LL, IN 46356	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		upper buttocks and the	TAG		DATE
		oose one of these areas to			
	•	and wipe the skin with			
	an alcohol swab.				
		the alcohol swab and			
	gloves.				
	18. Wash your h	ands"			
	Interview with I	PN #1 on 5/3/13 at 3:50			
		y sharps should be			
		sharps' container. LPN			
	#1 indicated then	re should be a sharps'			
	container in the	home. LPN #1 indicated			
	alcohol swabs sh	ould be used to clean and			
	sanitize the finge	er and the skin prior to			
	doing the blood	glucose test and prior to			
	administering cl	ient #1's insulin. LPN #1			
		ulin vial lid should also			
	be wiped with ar	n alcohol swab.			
		dministrative staff #1 on			
		M indicated the sharps'			
		red and there was one in			
	U 1	e. Administrative staff #1			
		ntainers the facility			
	-	nad an opening large			
	•	man hand. Administrative			
		d the Service Coordinator			
	_ ,	p home and was not able			
		tainer the surveyor had			
	described behind				
		taff #1 indicated sharps			
		appropriate container and			
	not laying aroun	d/on the container.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 44 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G116	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY PLETED 6/2013
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP	CODE	
ARC OF	NORTHWEST IND	IANA INC, THE		EFFREY DR .L, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAU	9-3-7(a)	A LOC IDENTIFY LING INFORMATION)	IAG	DEFECTION 1		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 45 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G116	B. WIN			05/16/2	2013
NAME OF P	DOMDED OF GUIDNI 155			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1734 JE	EFFREY DR		
	NORTHWEST INDI	·			L, IN 46356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000460	483.480(a)(1)	RITION SERVICES					
		receive a nourishing,					
		t including modified and					
	specially-prescrib						
	Based on observ	ation, interview and	W0	00460	Nursing staff will have trained		06/15/2013
		r 1 of 3 sampled clients			staff on the diabetic diets by		
		acility failed to assure the			6/15/13. In order to prevent		
		od in accordance with the			reoccurrence the Nurse in		
	client's diet order				conjunction with the Service Coordinator will train both hon	,	
	onent's diet orde				and day program on the diabe		
	F: 1: : 1 1				diet plan, this training will inclu		
	Findings include				a demonstration on making		
					exchanges and identifying		
	An evening obse	ervation was conducted at			appropriate day time snacks		
	the group home	on 5/1/13 from 5:30 P.M.			including modeling and return		
	until 7:00 P.M.	At 5:55 P.M., client #1			demonstrations of appropriate		
	served himself u	nmeasured amounts of			exchanges. A set of measure serving utensils will be obtained		
	food, which cons	sisted of chicken, whole			for this home and Client # 1 w		
	•	bread and sliced bread.			be trained on utilizing them as		
	nomer com, com	i oroda dira siroda oroda.			prefers to cook for and serve		
	A ravious of alias	nt #1's record was			himself. Observations will incl	lude	
					meal time, medication		
		3/13 at 4:15 P.M. Review			administration, and documentation review of the		
		st current Physician's			MAR, and blood sugar reading	ns	
		old indicated: "1800			In addition the Area Manager	-	
		eview of client #1's			audit the home on a monthly		
	Individual Suppo	ort Plan (ISP) dated			basis to ensure the serving		
	3/6/13 indicated:	"Individual's Diagnosis:			utensils are still available.		
	Diabetes Mellitu	s."			6/14/13To ensure future		
					compliance, The Service Coordinator will visit the home	,	
	A review of the	facility's 5/1/13 posted			once a week for 2 months and		
		at 6:15 PM, indicated			bimonthly thereafter to ensure		
		receive chicken, corn,			that the diabetic diet plan is be		
		iced bread. The 5/1/13			followed, the medication	-	
					administration record is accura	ate,	
		licate the specific serving			and blood sugar readings are		
	amounts.		I		documented and within the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet Page 46 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G116	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 05/16/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	1734 JE	ADDRESS, CITY, STATE, ZIP CODE EFFREY DR LL, IN 46356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	An interview with the Service Coordinator (SC) was conducted on 5/9/13 at 1:25 P.M. The SC indicated staff should have followed the client's prescribed diet. 9-3-8(a)		parameters established in the individuals risk plan, as well a active treatment taking place. Service Coordinator will also review client activity logs to ensure the clients are all being taken out into the community. 6/21/13 Professional staff will be on simonitor each meal, including weekends, until each staff has shown proficiency in prompting the client to follow his diabetic diet. Proficiency means staff successful when monitored without need for direction three consecutive times. This monitoring system will continuas long as is necessary until immets the proficiency level. Constaff has shown that they are proficient in diet management the diabetic client, including the use of measured serving uten monitoring will fade to three tians week, and then weekly x 4 weeks and two time per morongoing.	s The g te to /e g are e te conce of ne sils, mes

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JYXK11

Facility ID: 000653

If continuation sheet

Page 47 of 47